STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	10/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PARK NURSING CENTER	650 FAIRWAY DRIVE EVANSVILLE, IN47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00097310. Complaint IN00097310 Substantiated, Federal/State deficiencies are cited at F223 and F323. Survey dates: September 29, 30, and October 3, 2011 Facility number: 000069 Provider number: 155148 AIM number: 100288980 Survey team: Anne Marie Crays RN Census bed type: SNF: 10 SNF/NF: 83 Total: 93 Census payor type: Medicare: 16 Medicaid: 68 Other: 9 Total: 93 Sample: 6 These deficiencies also reflect state findings cited in accordance with 410 IAC	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0223 SS=A	16.2. Quality review completed 10/5/11 Cathy Emswiller RN The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse from a staff member, for 1 of 6 residents reviewed for abuse, in a sample of 6. Resident C Findings include: 1. On 9/29/11 at 1:30 P.M., the Director of Nursing [DoN] provided a "Fax Incident Reporting Form," sent to the Indiana State Department of Health. The form included: "Incident Date: 08-13-11, Incident Time: 7:00 pm, Resident Involved: Name: [Resident C]...Staff Involved (if applicable): #1 [CNA # 1], # 2 [CNA # 2], # 3 [RN # 3], Brief Description of Incident: ...Employee # 2 reported to Charge Nurse and DNS [director of nursing services] that she was in room [number], when resident stated, 'Why are you treating me like I am crazy?'	F0223	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after October 18, 2011. The facility submits a plan of correction for the following deficiency despite the facility maintaining substantial compliance. **F-223 Free from abuse/involuntary seclusion**It is the practice of this provider to ensure that the residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, or voluntary seclusion. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	10/18/2011

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	to [CNA # 1]. Employee # 1 loudly shouted at resident 'Because you are crazy.' Employee # 3 was in hallway and overheard loud voices and heard Employee # 1 state, 'You are a self centered woman in a non therapeutic tone.' [sic] Immediate Action/Interventions:...Employee # 2 notified Charge Nurse and DNS, DNS immediately asked Charge Nurse to remove employee from resident care. She was escorted to time clock and told not to reenter the building until investigation was completed...Employee, [CNA # 1] was terminated from employment on 08-18-2011 on violation of verbal inconsiderate care...." On 9/30/11 at 2:00 P.M., during interview with CNA # 2, she indicated she was working on 8/13/11 "and heard a commotion." CNA # 2 indicated she heard Resident C state, "Why do you keep calling me crazy," and heard CNA # 1 tell the resident, "You are crazy." CNA # 2 indicated she stayed with Resident C while the nurse took CNA # 1 away. 2. On 9/29/11 at 12:05 P.M., the Director of Nursing provided the current facility policy on "Abuse Prohibition, Reporting, and Investigation Policy and Procedure," dated February 2010. The policy included: "It is the policy of [facility corporation] to		**practice.**· C.N.A. # 1 was immediately suspended pending investigation· C.N.A. was terminated after completion of investigation· Facility monitored resident for any adverse affects to psychosocial well being. No psychosocial issues, no adverse affects and emotional well being stable. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**· Residents residing In the facility have the potential to be affected by the same practice· Staff will be in-serviced over abuse definitions, policy and reporting by SDC/designee on or before 10-18-11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur**· Staff will be in-serviced over abuse definitions, policy and reporting by SDC/designee on or before 10-18-11.· Abuse in-service training will be on a quarterly basis thereafter· ED/designee is responsible to ensure compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be pout into place?** · Abuse CQI tool will be utilized weekly x one month, monthly x 2 months then quarterly	

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	protect residents from abuse including physical abuse, sexual abuse, verbal abuse...Verbal Abuse - defined at the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability...." This federal tag relates to Complaint IN00097310. 3.1-27(b)		thereafter · Findings from the CQI process will be reviewed monthly for 3 months and then quarterly thereafter during the facility's monthly QAA meetings. An action plan will be implemented as needed for any deficient practice. **Compliance Date: 10/18/11**	

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F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure two staff assisted a dependent resident to transfer and failed to then supervise the resident while in the bathroom, resulting in a fall; and utilized alarms in place of supervision for a resident at risk for falls, resulting in a fall with a resulting subdural hematoma, for 2 of 4 residents reviewed for falls, in a sample of 6. Residents B and C Findings include: 1. On 9/29/11 at 9:20 A.M., during the initial tour, the Director of Nursing [DoN] and LPN # 1 indicated Resident B had fallen recently, hit her head, and received a "black eye." LPN # 1 indicated Resident B was not interviewable. On 9/29/11 at 11:50 A.M., Resident B was observed sitting up in a wheelchair in her room. A leg brace was observed on the resident's right leg, and the resident was wearing a protective helmet. A clip alarm was attached to the resident.	F0323	**F-323 Free of accident/hazard/Supervision/devices**It is the practice of this facility to ensure that the resident's environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**· Resident B's chart including to but not limited to the fall care plan has been reviewed and revised if indicated.· Resident C no longer resides in this facility.· Resident B's interventions are in place and functioning per observation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**· All residents have the potential to be affected by this alleged deficient practice.· Audit of fall care plans has been completed and compared to the c.n.a. assignment sheets for accuracy.· Observation of residents reveal	10/18/2011

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	The clinical record of Resident B was reviewed on 9/29/11 at 11:55 A.M. Diagnoses included, but were not limited to, Fractured right ankle, Developmental Disability, Seizure, and Legally Blind. The resident was admitted to the facility following a fall in which she fractured her ankle. A Physician's order, dated 8/22/11, indicated, "...Resident requires limited assist for bed mobility, assist x 2 for transfer - while maintaining NWB [no weight bearing] at Right LE [lower extremity]. Wheelchair for mobility. Care Plan Update, Problem Weakness, difficulty [with] transfers, Poor stand. balance, foot pain...." An admission Minimum Data Set [MDS] assessment, dated 8/30/11, indicated the resident was unable to complete an interview for mental status, had a short-term and long-term memory problem, and required extensive assistance of two+ staff for transfer and toilet use. A test for balance while moving from seated to standing position, moving on and off toilet, and surface-to-surface transfer indicated: "Not steady, only able to stabilize with human assistance." A Fall Risk Assessment, dated 9/8/11,		that fall interventions are in place and functioning. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur**· Nursing staff have been in-serviced on fall interventions/use of c.n.a. assignment sheets, not leaving dependent residents alone in the bathroom on or before 10-18-11 by DNS/Designee.· Placement of fall interventions will be checked every shift and as needed throughout the facility by charge nurses reviewing the TAR (Treatment Administration Record).· Interdisciplinary Team (IDT) will meet 5 times a week to review each fall and conduct a root cause analysis to determine the reason for the fall and ensure appropriate interventions are in place. The IDT will re-review in 3 days to evaluate the effectiveness of the intervention(s).· DNS/designee will be responsible to ensure compliance · Non compliance with policy and procedure will result in further training including disciplinary action **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**· A falls CQI audit tool will be completed with every fall that occurs weekly x 1 month, monthly x 2 months then quarterly	

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	indicated, "...Resident has had a history of falls within the past 3 months? Yes...Resident has impaired vision? Yes...Resident has diagnosis of and/or demonstrates evidence of impaired gait/balance? Yes...If any answer above is 'Yes,' the resident is at risk for experiencing a fall. Proceed to care plan with appropriate interventions based upon the risk factor(s)." A Care Plan, dated 8/31/11, indicated a problem of "Resident is at risk for fall due to: Blindness, congenital micrcephalus [sic], and epilepsy." The Approaches included: "Call light in reach, Environmental changes, Personal items in reach, Resident to wear helmet when up in w/c [wheelchair]." An approach, dated 9/16/11, indicated, "Educate staff that resident is to be dressed and undressed while seated on the edge of the bed." A Fall Circumstance Report, dated 9/14/11, included: "[Resident B], Date/Time of fall: 9/14/11 @ 1930 [7:30 P.M.]...Describe what the resident was doing prior to the fall...Sitting on toilet, screaming her 'toe hurts get the nurse.' CNA called for nurse - left resident to get nurse. Instruct [sic] to stay seated. Describe the position of the resident when first observed after fall...Sitting on floor holding head, screaming [and] crying,		thereafter· DNS/designee will be responsible for completing the CQI audit tool.· Findings from the CQI process will be reviewed monthly for 3 months and then quarterly thereafter during the facility's monthly QAA meetings. An action plan will be implemented as needed for any deficient practice. **Compliance date: 10/18/11**	

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	[Right] leg crossed [beneath] [left] leg...Describe location of the fall...Res [resident] Bathroom...c/o [complains of] 'head hurts'...Describe injuries...Res. hit head on sink when falling, has a hematoma (closed) 3.0 x 3.0 [centimeters] @ 1945 [7:45 P.M.] raised slightly...Resident or witness statement of how fall occurred: Apparently res. slid off toilet while waiting for CNA to get nurse...What intervention(s) was put in to place to prevent another fall? 1. Never leave alone in BR [bathroom]. 2. Undress [and] dress in bed -while sitting up." An Interdisciplinary Team [IDT] Progress Note, dated 9/16/11, indicated: "IDT this date for fall of 9/14 @ 1930. Resident being toileted by staff CNA...CNA stepped away to call for nurse. Resident fell hitting head on since receiving hematoma (closed) 3.0 x 3.0. Immediate interventions: Staff education - never leave resident alone in B.R....Take helmet off very last thing before lying down in bed." On 9/30/11 at 9:10 A.M., the DON provided documentation of inservicing she gave the staff regarding not leaving a dependent resident alone on the commode.			

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	2. The closed clinical record of Resident C was reviewed on 9/30/11 at 9:25 A.M. Diagnoses included, but were not limited to, Osteoporosis, Anxiety, Bipolar Disorder, Subdural Hematoma, and Subdural Hemorrhage. The resident was readmitted to the facility on 8/29/11, following a stay on a psychiatric unit. A hospital discharge note, dated 8/29/11, indicated: "...The patient needs assistance with her activities of daily living because of her limited cognitive and physical ability...." The resident was started on Depakote [medication used to treat behaviors] and Ativan [an anti-anxiety medication] while at the hospital. A Care Plan, initially dated 2/8/11 and updated 9/16/11, indicated a problem of "Resident is at risk for fall due to: unsteadiness." The Approaches included: "9/14/11 Room move closer to nurses station, 9/14/11 Assist of 1 when up with walker, 9/14/11 Bed to low position, 9/14/11 Toilet every 2 hours, 8/31/11 Assist of 1 when up, 8/31/11 Pressure alarm in bed and chair, 2/8/11 Call light in reach, 2/8/11 Environmental changes: [blank], 2/8/11 Non skid footwear, 9/16/11 Mat at bedside, 9/13/11 Non skid socks @ all times."			

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	Nurses Notes included the following notations: 8/29/11 at 4:30 P.M.: "Returned to facility...Ambulating [with] walker [and] driver of van to new room...." 8/29/11 at 6:15 P.M.: "Heard knocking this nurse went to investigate found resident sitting on floor [with] left knee/leg under [right] knee et [and] bleeding from forehead. Noted large hematoma - Assessed for injury then [assisted] [with] 2 [assist] to loveseat...." The resident was sent to the emergency room at 6:50 P.M. and returned the same night. A Fall Risk Assessment, dated 8/30/11, indicated: "Readmit...Resident has history of falls within the past 3 months? Yes...Resident has diagnosis of and/or demonstrates evidence of impaired gait/balance? Yes...Resident is confused and/or disoriented? Yes...." A Fall Circumstance Report, dated 8/29/11, included: "...States that she was up to close the door [and] fell. found on floor by door walker tipped over...[Right] shoe off, head bleeding, confused...Describe injuries...Lg [large] Hematoma [with] 3.0 x 0.1 [centimeters] laceration to mid forehead...Resident or			

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	witness statement of how fall occurred: Was noted sitting on loveseat [after] ADON [assistant director of nursing] [assisted] her to sitting position [after] finding her up straightening her bed...within 5 min she had fallen...Has the resident been prescribed any new medications within the past 7 days? Depakote sprinkles started 8/26/11...Document any environmental factors observed...: New room, returned to facility @ 1630 [4:30 P.M.] [after] being in hospital for behaviors. What intervention(s) was put in place to prevent another fall?...When returns will be on 15 min checks. Tab alarm...Toilet [every] 2 [hours]." Nurse's Notes continued: 9/5/11 at 12:10 P.M.: "Resident [up] in w/c [wheelchair]. Is alert but confused. Call light kept in reach...Tabs alarm on. Has gotten [up] and out of w/c on own x 1 today. Practice discouraged...Will cont to monitor." 9/8/11 at 9:00 P.M.: "...Was attempting to stand several times, lots of 1:1 tonoc [sic], to monitor for safety...." 9/11/11 at 3:00 A.M.: "Resident attempted to get OOB [out of bed] alone a couple of times tonoc [sic] [without]			

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	assist. Bed alarm sounded each [time]. Resident assisted back to bed. Each time CNA warned resident of dangers of falling...Resident kept talking over the top of CNA et refused to listed...Entire time resident talking in disjointed sentences...Very unsteady when up alone...has some trouble understanding others even when she has hearing aides in." 9/12/11 at 1:00 A.M.: "Resident up out of bed [without] assist...." 9/12/11 at 1:10 A.M.: "Resident up out of bed talking loud voice trying to walk in hallway et open doors of other resting residents...." 9/12/11 at 1:38 A.M.: "Resident up in room [without] assist in loud voice saying get me out of here...brought back to NS [nursing station] for short period of x...." 9/12/11 at 11:00 P.M.: "...Climbing out of bed many times...." A Fall Circumstance Report included: "[Resident C], Date/time of fall: 9/13/11 at 9:00 A.M....Describe the position of the resident when first observed after fall: Lying on [right] side. Head against bathroom wall, pajamas [and] brief [down] around knees...Did resident hit			

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	his/her head? Yes...[No] injuries...Resident or witness statement of how fall occurred: [No] witness [and] resident unable to tell what happened. [In different writing] Alarm sounding in bed, gown [with] tabs removed...What intervention was put in place to prevent another fall? Non skid socks even when in bed." A Nursing Note, dated 9/13/11 at 1:20 P.M., indicated, "...Remains on 15 min [checks]...Call light in reach when in room. Often does not use as was case this AM...received order to [decrease] Depakote from total of 1000 mg QD [every day] to 750 mg QD...." A Fall Circumstance Report included the following: "[Resident C], Date/time of fall: 9/14/11/0620 AM...Describe the position of the resident when first observed after the fall: She is side-lying on floor with knees slightly flexed...Describe injuries...Open area above [right] eyebrow...Bruise on periorbital [around eye] area on [right] eye is 5.5 x 2 cm [centimeters], the open area is 3.2 x 1. Bruise on [right] hip is 6 x 6 cm. Resident or witness statement of how fall occurred: Resident is confused [and] disoriented. Her 6 AM pill [name] was just give [sic] 5 mins. prior to fall. Resident heard calling for help. Pressure			

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	alarm sound off. The alarm attached to her gown did not sound off because she took the gown off...What intervention was put in to place to prevent another fall? I asked my CNA to stay with the resident while I call MD, Family, [and] DON. Resident was sent to ER. Will move Res to Room closer to Nurses Station." A Nursing Note, dated 9/14/11 at 2:30 P.M., indicated, "Call placed to [hospital]. Spoke [with] nurse on ICU. States resident admitted to ICU [room number] [with] subdural bleed (slight)...." A Hospital note, dated 9/14/11, indicated, "...This patient was at the nursing home. Apparently she fell from a standing position. She does not remember the incident but she may not be able to remember anything...X-Rays: 8mm right subdural hematoma...." Hospital discharge instructions, dated 9/16/11, indicated, "...Pt [patient] requires 24 hour supervision and assistance when out of bed...." On 9/30/11 at 2:15 P.M., during interview with the DoN, she indicated the resident had 2 alarms on when she fell on 9/13/11 and 9/14/11. The DoN indicated on both occasions the resident fell, the pressure alarm sounded, and staff responded to that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	10/03/2011

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	alarm. The DoN indicated the tabs alarm was attached to the resident's gown, which the resident removed, so the tabs alarm did not sound either time. 3. On 10/3/11 at 1:00 P.M., the Director of Nursing provided the current facility policy on "Fall Management Program," revised 3/10. The policy included: "It is the policy of [corporation] to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls...All new admissions will be considered a fall risk based upon his/her new living arrangements, and his/her reasons for being admitted...A care plan will be developed at time of admission specific to each resident based upon the results of the fall risk assessment. Charge nurses will communicate the specific care required for each resident to the assigned caregiver on each shift...." This federal tag relates to Complaint IN00097310. 3.1-45(a)(2)			

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